STATE OF MICHIGAN
CIRCUIT COURT FOR THE 30TH JUDICIAL DISTRICT
INGHAM COUNTY

LINDA A. WATTERS, COMMISSIONER,
OFFICE OF FINANCIAL AND INSURANCE
SERVICES FOR THE STATE OF MICHIGAN,

Petitioner,

v

File No. 98-88265-CR
Hon. James R. Giddings

MICHIGAN HEALTH MAINTENANCE
ORGANIZATION PLANS, INC., a
Michigan health maintenance organization,
doing business as OmniCare Health Plan,

Respondent.
_____/

MARK J. ZAUSMER (P 31721)
AMY M. SITNER (P 46900)
Zausmer, Kaufman, August & Caldwell, P.C.
Attorneys for Petitioner
31700 Middlebelt Road, Suite 150
Farmington Hills, Michigan 48334
248/851-4111

LIQUIDATOR'S BRIEF AS TO CLAIM PRIORITY DETERMINATION

Linda A. Watters, the Liquidator of Michigan Health Maintenance Organization Plans, Inc., through her attorneys, Zausmer, Kaufman, August & Caldwell, P.C., files this brief on the issue of the respective priorities to be assigned to claims filed against Michigan Health Maintenance Organization Plans, Inc.

I. STATEMENT OF FACTS

A. General Background

Michigan Health Maintenance Organization Plans, Inc., formerly known as OmniCare Health Plan ("OmniCare") was placed in liquidation by this Court on October 28, 2004. Order for

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

Liquidating Receivership and Declaration of Insolvency, dated October 28, 2004 ("Liquidation Order").[1] Before being placed in liquidation, OmniCare was in rehabilitation, also pursuant to an Order of this Court. Order of Rehabilitation and Injunctive Relief, dated September 11, 2002. Before being placed in rehabilitation and then liquidation, OmniCare was controlled by United American HealthCare Corporation ("UAHC"). *See* Liquidation Order.

The Commissioner as Liquidator, under the supervision of this Court, is proceeding rapidly in her efforts to complete the Liquidation of OmniCare. On July 20, 2005, at 4:00 p.m., as the next major step in the Court-supervised liquidation process, a hearing will be held to determine the priority of claims. This brief presents the Liquidator's claim priority analysis.

B. Medical Providers

Most of the claims in this case have been filed by medical providers. With regard to these claims it is important to note the significance of the fact that OmniCare, pre-liquidation, was a health maintenance organization ("HMO"). It provided services to members through a network of providers. OmniCare members dealt with these providers under contractual arrangements for medical services. These providers did not seek payment from OmniCare members directly. Rather, OmniCare paid the providers, which were generally barred from seeking payment (except for agreed co-pays) directly from the OmniCare members. OmniCare obtained the money to pay the providers either from premiums paid by OmniCare members or, in the case of Medicaid patients who formed a major part of the OmniCare clientele, from designated Medicaid funds for these patients. Affidavit

---

[1] Unless otherwise specified, all court documents referenced are those in this case. Because all such documents are in the Court's file and are available to all parties and to the public at: http://www.michigan.gov/mda/0,1607,7-154-10555_13251_16735---,00.html on the State of Michigan's website, copies of most of the referenced documents are not attached to this Brief.

of Winifred W. Hicks, Exhibit A. Thus, OmniCare acted similarly to a traditional insurance company in dealing with network medical providers serving OmniCare members. The members went to the providers for services; OmniCare paid the providers; OmniCare received the money to pay for the services from regular fees, similar to premium payments, paid by the member or their employees, or from funds paid on members' behalf by government agencies.

There were two primary distinctions between the way OmniCare and traditional insurance companies operate financially. First, if OmniCare failed to pay a participating provider, the provider was still barred from seeking direct payment from the OmniCare members, whereas a provider would not have been barred from seeking payment from an insured of a traditional insurance company. Second, payment for medical services given by providers to OmniCare members always went directly from OmniCare to the providers, with no checks being written by OmniCare to its members, because, except for co-pays, members were never billed directly by providers, as sometimes happens with traditional insureds.

C. The Detroit Medical Center's Claims

As the Detroit Medical Center ("DMC") explains in its brief, DMC has both a claim for recovery for medical services it provided to OmniCare members (DMC's Exhibit A) and a separate proof of claim alleging that OmniCare, while in rehabilitation, entered into a capitated contract with DMC that was based on allegedly flawed compensation figures (DMC's Exhibit B). The Liquidator does not dispute that the claims attached in DMC's Exhibit A should be treated in the same manner as other provider claims. However, the priority classification of amounts sought in DMC's Exhibit B is more complicated, as is discussed later in this brief.

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

D. The Federal Medicare Agency

The Centers of Medicare and Medicaid Services of the United States Department of Health and Human Services ("CMS") alleges it paid providers for certain OmniCare members who were covered by Medicare.[2] Upon discovering that these members received their Medicare coverage through OmniCare, CMS sought repayment of the amounts it had paid on the members' behalf. CMS asserts in its claim priority brief that under federal statute (42 USC 1395y(b)(2)(B)(iv)) and regulation (43 CFR 411.26(a)), its rights are subrogated to those of the parties for whom and to whom it made payment. This assertion appears to be correct, and the cited federal statutes are controlling in this case under the Supremacy Clause of the United States Constitution. US Const, art VI, sec 2.

E. UAHC

Before OmniCare went into rehabilitation, OmniCare and UAHC were affiliated companies with interlocking boards of directors. During this period, UAHC effectively controlled OmniCare. UAHC had leased office equipment, including both furniture and technological components, such as a phone system and computers, to OmniCare. UAHC asserts that for the first part of the period OmniCare was in Rehabilitation, from shortly after the July 31, 2001 Rehabilitation Order through October 31, 2002, the Rehabilitator paid UAHC monthly lease payments of $86,882 for all of this equipment. UAHC then proposed replacing the lease arrangement with an Asset Purchase Agreement, eliminating the lease obligation and substituting a flat purchase price of $800,000.

---

[2]Facts available to the Liquidator at this time indicate that CMS does not have a valid claim because amounts owed to CMS were offset, several years ago, against other amounts owed to OmniCare. If this determination is upheld by this Court (if challenged), the question of the priority due to CMS's claim will become a moot point.

However, the Rehabilitator rejected the proposed agreement, which was never signed.[3]

UAHC claims it was not paid for the equipment during the remaining rehabilitation period, although the equipment was used in operating OmniCare. UAHC asserts that it is entitled to be paid for the use of the equipment as a cost of administration, entitling its claim to Class 1 priority under MCL 500.8142(1)(a) . As set out in detail infra in the legal discussion, UAHC's argument ignores the fact that the case is no longer in rehabilitation but in liquidation, and *rehabilitation* expenses cannot be claimed as *liquidation* costs of administration. Moreover, it should be noted that UAHC did not file a proof of claim.

F. State Agencies

Two state agencies argue that their claims should be given Class 1 priority as costs of administration. The Attorney General asserts a claim for legal services delivered during both the rehabilitation and liquidation periods. The Department of Community Health asserts a claim for quality assurance assessments, an assessment on HMO's used as a source of funding for the Medicaid program. It appears that all of DCH's claim matured during the rehabilitation period. Similar to UAHC, to the extent that both state agencies' claims matured during the rehabilitation phase of proceedings, neither can properly assert that its claim should be given Class 1 priority as a cost of administering the liquidation. Claims of state agencies incurred during the rehabilitation period fall under Class 6.

[3] For the purposes of this brief, the Liquidator accepts UAHC's factual assertions as true, but the Liquidator reserves the right to object to those allegations, if appropriate, at a later date.

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

II. LEGAL ARGUMENT

A. Claim Priority Determination Is Not an "Academic" Question.

The Detroit Medical Center suggests in its brief that because most of the claims in this case are either from medical providers or claims involving costs of administration, claim priority may be an "academic" question. This suggestion is incorrect. Although "most" of the claims, even the overwhelming majority of them, may fall into these two categories, the order in which claims are paid makes a difference in a liquidation where full payment of claims is uncertain. For example, as discussed below, the relative priority given the large claim of UAHC has far more than "academic" significance. Further, by statute, an orderly payment of claims pursuant to the Liquidation is required. MCL 500.8142. Therefore, it is appropriate for the Court, under MCL 500.8142(1), to determine the order of priority under which claims will be paid.

B. MCL 500.8142(1) Provides the Statutory Basis for Determining Claim Priorities.

MCL 500.8142(1) sets out the rules for determining the priority to be given to different types of claims against a delinquent insurer or HMO. The priorities are set out in descending order, with a separate subsection devoted to each priority class. The statutory section is appended to this brief as Exhibit B, and the specific provisions are detailed further in connection with specific points of analysis, but its provisions may be summarized as follows.

MCL 500.8142(1)(a) gives the highest priority, Class 1, to "costs and expenses of administration." This includes not only administrative expense in the strict sense of the phrase, such as legal and supervisory fees, and employee claims for certain services rendered, but also "[t]he actual and necessary costs of preserving or recovering the insurer's assets." MCL 500.8142(1)(a)(i).

MCL 500.8142(1)(b) gives the next highest status, Class 2, to "all claims under policies for

losses incurred, including third party claims, and all claims of a guaranty association or foreign guaranty association." After setting out exceptions irrelevant to this case pertaining to reinsurance and to life insurance, it adds, "That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class."

MCL 500.8142(1)(c) gives Class 3 status to all federal government claims.

MCL 500.8142(1)(d) gives Class 4 status to "[a]ll claims against the insurer for liability for bodily injury, or for injury to or destruction of tangible property that are not under policies," and also to certain types of employee claims.

MCL 500.8142(1)(e) places in Class 5 "[c]laims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors." Only the last portion, claims of general creditors, would appear to be relevant here.

MCL 500.8142(1)(f) gives Class 6 status, with certain limitations, to state and local government claims.

MCL 500.8142(1)(g) defines, as Class 7 claims, "Claims filed late or any other claims other than claims under subdivisions (h) and (i)."

MCL 500.8142(1)(h) provides Class 8 status for "[s]urplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies are limited in accordance with law.

MCL 500.8142(1)(i) relegates to Class 9 status "[t]he claims of shareholders or other owners." It further provides, "In paying claims pursuant to this class, disinterested shareholders have priority over interested shareholders who are directors or officers who fail to exercise their duties in accordance with [MCL 500.]5240."

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

C. Applicable Rules of Statutory Interpretation

The primary goal of statutory interpretation is to give effect to the intent of the legislature. *People v Stone*, 463 Mich 558, 562; 621 NW2d 702 (2001). In interpreting a statute, the court considers both the plain meaning of a critical word or phrase and its placement and purpose in the statutory scheme. *Sun Valley Food Co v Ward*, 460 Mich 230, 237; 596 NW2d 119 (1999). If the statutory language is unambiguous, it is presumed that the legislature intended the clearly expressed meaning, and judicial construction is neither required nor permitted. *DiBenedetto v West Shore Hosp.* 461 Mich 394, 402; 605 NW2d 300 (2000). When the language of the statute is not plain but is subject to varying interpretations, the court looks to the purpose of the enactment to ascertain legislative intent. *Dean v Dep't of Corrections,* 453 Mich 448, 454; 556 NW2d 458 (1996). The court should apply a reasonable interpretation that best accomplishes the legislature's purpose. *Rowell v Security Steel Processing Co,* 445 Mich 347, 354; 518 NW2d 409 (1994). While case law is often helpful in construing statutory language, the Rehabilitator has located no case law applying Chapter 81 to a delinquent HMO.

Laws that involve insurance are affected with public interest and therefore must be liberally construed in favor of policyholders, creditors and the general public. *Yetzke v Fausak*, 194 Mich App 414, 421; 488 NW2d 222, *app den* 441 Mich 889; 495 NW2d 383 (1992). *See also Att'y Gen'l v Michigan Surety Co,* 290 Mich 33, 43; 287 NW 368 (1939); *DePyper v Safecto Ins Co,* 232 Mich App 433, 441; 591 NW2d 344, *app den* 460 Mich 873; 601 NW2d 100 (1999); *Szabo v Ins Comm'r,* 99 Mich App 596, 599; 299 NW2d 364 (1980). The language of an insurance statute should be construed in the most beneficial way to prevent absurdity, hardship or injustice, to favor public convenience, and to oppose all prejudice to public interest. *Yetzke, supra* at 421. Where the

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

legislature has properly delegated authority to an administrative agency to carry out the mandates of a statute, the courts should give great deference to the agency's interpretation of the provision, although they are not bound by it. *Szabo, supra* at 598; *see also Bruhan v Plymouth-Canton Community Schools,* 425 Mich 278, 282-283; 389 NW2d 85 (1986); DAIIE v *Comm'r of Ins,* 119 Mich App 113, 119; 326 NW2d 444 (1982).

D. Principal Points in Controversy Among the Claimants

Most of the claims filed in the liquidation, except those for costs of administration, have been filed by providers of medical services to OmniCare members. As set forth below, the Liquidator believes that the providers' claims are entitled to be treated as Class 2 claims. This is because with an HMO, as OmniCare was when it went into liquidation, amounts expended on medical services are the "losses incurred" against which the HMO plan insures. Therefore, they precisely meet the statutory definition of Class 2 claims. MCL 500.8142 (1)(b). The same principle, together with applicable federal law, gives Class 2 status to the claim of the Medicare system.

The other principal question is the priority of the alleged claim of UAHC, which controlled OmniCare before it went into rehabilitation, for payment for use of office equipment by OmniCare during the rehabilitation period. UAHC's argument that this is an expense of liquidation administration fails because the expense was incurred during the rehabilitation period, not the liquidation period. UAHC's claim would only be that of a general creditor, placing the claim into Class 5 under MCL 500.8142(1)(e). UAHC's failure to file a proof of claim form, however, should bar this claim entirely.

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

E. Medical Service Providers

A number of medical service providers have filed briefs arguing that their claims are for losses incurred as third parties under the contracts or policies of OmniCare members, and as such, they are entitled to Class 2 status under MCL 500.8142(1)(b). The Rehabilitator agrees.

MCL 500.8142(1)(b) reads:

> Class 2. Except as otherwise provided in this section, all claims under policies for losses incurred, including third party claims, and all claims of a guaranty association or foreign guaranty association. However, obligations of an insolvent insurer arising out of reinsurance contracts shall not be included in this class.

The essential question is what the phrase "claims under policies for losses incurred" means in the context of an HMO delinquency. It is a cardinal rule of statutory construction that if "two statutes arguably relate to the same subject or share a common purpose, the statutes are in pari materia and must be read together as one law . . . . If statutes lend themselves to a construction that avoids conflict, then that construction should control." *People v Webb,* 458 Mich 265, 274; 580 NW2d 884 (1998).

Under this principle, MCL 500.8142(1)(b) and MCL 500.3503, applying the regulations of the Insurance Code to regulation of HMO's, clearly are in pari materia, and therefore must be interpreted consistently. Doing so means determining what sort of loss is incurred under an HMO contract, in the same way that the determination would be made with respect to an insurance policy. To determine what constitutes a "loss incurred" with respect to an HMO policy or contract, therefore, it is necessary to begin by asking what sort of damage or loss an HMO policy or contract protects an HMO member against, just as losses incurred under an insurance policy are determined by looking at the loss or damage the insurance policy protects an insured from.

The answer to this question is clear, from the state framework for regulation of HMO's, from

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

the way HMO contracts are written, and from the way HMO accounting and financial and actuarial statements (including those of OmniCare) are prepared. HMO members look to avoid financial loss that would occur if they had to pay for medical services themselves. HMO policies protect them from these losses through the HMO, for a fee, either providing medical services directly, or contracting with third parties who will provide the services. These third parties are then paid directly by the HMO and are prohibited from seeking repayment directly from the HMO members. The only real difference, in this regard, between an HMO contract or policy and a more traditional medical insurance policy is that under a traditional insurance policy, the insured is theoretically initially liable to pay the medical provider[4] and then is reimbursed by the insurance company, while under an HMO policy, the payment is made directly by the HMO to the provider of services, with the HMO member never seeing an actual bill. In both cases, the loss incurred is the same — the cost incurred for medical services. Under a traditional policy, it may sometimes but not always be the insured who suffers this loss, if the insured pays a medical bill before the insurance company writes the check. With an HMO, the loss is incurred by the party that provides the services to the HMO member without being able to seek payment directly from the member; it must look to the HMO for payment. In either event, medical services are the losses. The only difference (if any) is who gets the check to avoid the loss. With an HMO contracting with medical providers, this is a third-party service provider, and the statute specifically recognizes that these claims are covered under Class 2 by adding immediately after the phrase "losses incurred," the words, "including third party

[4] In practice, of course, this initial liability is now frequently waived, with the provider waiting for insurance company payment before seeking reimbursement from the insured.

claims." [5]

On the other hand, HMO members themselves do not suffer losses under their HMO contract. In fact, the HMO contract protects them against suffering loss by not only providing for the rendering of services, but insuring that they will never directly see a bill from contracting providers for services rendered. See Affidavit of Winifred W. Hicks (Exhibit A); see also MCL 500.3529(3). The losses, then, that are suffered are the losses of providers, not members, which bear the risk of not being paid.

F. The DMC "Breach of Contract" Claim

As explained above, DMC filed both standard claims for reimbursement for medical services it provided and a separate claim alleging that it incurred a loss as a result of what amounts to purported bad faith or misrepresentation by OmniCare in negotiating and administering a contract for the provision of medical services. The Liquidator is currently evaluating the latter claim (DMC's Exhibit B), from both legal and factual perspectives, and has not yet presented the DMC with the Liquidator's conclusions regarding the claim. However, it is fair to say the Liquidator is strongly dubious about the validity of this claim. Even in the event that DMC were to recover any amount under that claim, however, only amounts that were determined to be directly incurred in the provision of medical services would qualify for Class 2 priority. Any potential recovery related to DMC's allegations of misrepresentation or bad faith by OmniCare that resulted in compensation

[5] In the case of standard medical insurance, the medical provider supplying the insured with the service for which payment is owed is such a third party. To fail to apply the same logic when an HMO rather than a traditional insurance company is paying for the service would be to punish medical providers for doing business with HMO's. This would be not only unfair and illogical but also contrary to the purpose of the 2000 amendment making the Insurance Code applicable to HMO's, as discussed *supra*.

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

beyond simple payment for medical services should be given a Class 5 (general creditor) status.

G. CMS

CMS, the federal Medicare agency – similar to standard medical providers – is entitled to Class 2 status for any valid claim that it may have.[6] The payments it made were "claims under policies for losses incurred." MCL 500.8142(1)(b). Of course, the payments represented third party payments for people whose medical expenses Medicare is set up to cover. MCL 500.8142(1)(b) specifically states that it covers all such claims, "including third party claims." Moreover, as CMS points out in its brief, 42 USC 1395y(b)(2)(B)(iv), states, "The United States shall be subrogated (to the extent of payment made under this subchapter for such an item or service) to any right under this subsection of an individual or other entity to payment with respect to such item or service under a primary plan." The language it quotes from the regulation, 43 CFR 411.26(a), states: "(a) Subrogation. With respect to services for which Medicare paid, CMS is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a third party payer." These provisions — binding in this case under the Supremacy Clause of the Unites States Constitution (US Const, art VI, sec 2) — give CMS subrogation rights, giving it the same status as the patients for whom it made payments, and the providers to whom it made them, which makes its claim a Class 2 one.[7]

G. UAHC

---

[6]As noted *supra,* the Liquidator currently believes that CMS does not have a valid claim.

[7] Were it not for the controlling federal statute, it is arguable that MCL 500.8142(1)(c) would give this claim, and any other federal government claims, Class 3 status.

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

UAHC controlled Omnicare before it went into rehabilitation. Its claim for office equipment used during rehabilitation has been described above. As UAHC candidly admits, this equipment was used during rehabilitation, not during liquidation — indeed, UAHC's argument that the equipment was vital to OmniCare's continued operation would hardly make sense in the context of a company being liquidated. There might be an argument for treating payment for the equipment as a cost of administration if the case were still in rehabilitation, but it is not. That the liquidation is not a mere continuation of the rehabilitation, and that liquidation claims are separate from rehabilitation claims, is clear not only from the distinct statutory frameworks for the two types of proceedings, but from the last paragraph of this Court's Liquidation Order, which states, "IT IS FURTHER ORDERED that all claims against the assets of Michigan Health Maintenance Organization Plans, Inc. (formerly known as OmniCare Health Plan) must be made by filing claims in the receivership created hereby. The deadline for filing of claims shall be five months from the date of this order unless otherwise directed by the Court." Therefore, it is the law of the case that liquidation claims are in a separate category from rehabilitation claims, and so what might have been a rehabilitation cost of administration cannot be treated as a liquidation cost of administration.

UAHC did not file any proof of claim form with the liquidation estate and therefore cannot recovery any amount in this proceedings. Assuming for purposes of argument that UAHC has any claim at all, it would fall under Class 5.

H. State Government Claims

MCL 500.8142(1)(f) gives Class 6 status to state government claims, and this is the status that both DCH's claim and that of the Attorney General, for the most part, should receive.

Both agencies argue for MCL 500.8142(1)(a) Class 1 cost of administration status because

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

they allegedly provided services that helped keep OmniCare running during the rehabilitation period. However, precisely because these claims accrued during the rehabilitation period, they cannot provide the basis for cost of administration status during the liquidation. It should be noted, however, that some of the legal services performed by the Attorney General were performed for purposes of establishing the liquidation proceeding and during the liquidation period. To the extent that the claim is otherwise valid, the portion of the Attorney General's claim for legal services performed in connection with the liquidation proceedings would fall into Class 1.

DCH also advances the equitable argument that the needs of Medicaid patients are so important that liberal construction requires Class 1 treatment so that these needs can be met. This is a classic example of the sort of policy argument that must be presented to the Legislature, not the courts. E.g., *Levy v Martin,* 463 Mich 478, 487; 620 NW2d 292 (2001). DCH further asserts that by doing business with OmniCare under a Medicaid contract while OmniCare was in rehabilitation, it helped it stay in business. Besides the fact that this does not support a liquidation claim for administrative expenses, this claim is factually untrue.[8]

Alternatively, DCH argues that if it cannot receive Class 1 administrative expense status, it deserves Class 5 status as a general creditor, and that if it does not receive this treatment, it should receive Class 6 status as a state government claim. It offers no basis for showing how its claim is that of a general creditor rather than being precisely what it is, a state government Class 6 claim.

---

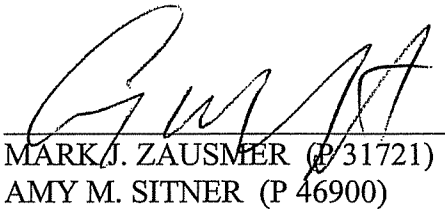
[8] In fact, the contract was a money-loser for OmniCare. As this Court was advised during the rehabilitation, the Medicaid members serviced under the DCH contract had a high acuity level, creating a disparity between the costs incurred and the revenues received. DCH was aware of this fact, but did nothing to provide additional funding to OmniCare in light of these higher acuity levels. OmniCare, which had this population of Medicaid members transferred to it from Detroit Medical Center pre-rehabilitation, in 2001, then was unable to meet new qualifications for the Medicaid contract when DCH re-bid it. This was a decisive factor in truncating the rehabilitation and forcing OmniCare into liquidation.

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

III. CONCLUSION

The Liquidator accordingly respectfully asks that the Court enter an Order setting claim priorities according to the principles set forth herein.[9]

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.



MARK J. ZAUSMER (P 31721)
AMY M. SITNER (P 46900)
Attorney for Petitioner
31700 Middlebelt Road, Suite 150
Farmington Hills, Michigan 48334
248/851-4111

DATED: July 8, 2005

[9]The Liquidator asks the Court to hold in abeyance the ultimate decision on the priority of DMC's "breach of contract" claim, other than any portion of that claim that may be stipulated to be solely in repayment of medical services provided, pending ultimate resolution of that claim.

STATE OF MICHIGAN
CIRCUIT COURT FOR THE 30TH JUDICIAL DISTRICT
INGHAM COUNTY

LINDA A. WATTERS, COMMISSIONER,
OFFICE OF FINANCIAL AND INSURANCE
SERVICES FOR THE STATE OF MICHIGAN,

Petitioner,

v

MICHIGAN HEALTH MAINTENANCE
ORGANIZATION PLANS, INC., a
Michigan health maintenance organization,
doing business as OmniCare Health Plan,

Respondent.
_____/

File No. 98-88265-CR
Hon. James R. Giddings

A.G. No. 1998053333A

MARK J. ZAUSMER (P 31721)
AMY M. SITNER (P 46900)
Zausmer, Kaufman, August & Caldwell, P.C.
Attorneys for Petitioner
31700 Middlebelt Road, Suite 150
Farmington Hills, Michigan 48334
248/851-4111

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

PROOF OF MAILING

COUNTY OF OAKLAND)
) ss
STATE OF MICHIGAN)

FREDA A. RUCINSKI states that on July 8, 2005, she served a copy of the Liquidator's Brief As To Claim Priority and Proof of Mailing by enclosing copies of said documents in sealed envelopes, with prepaid, first-class postage affixed and addressed to:

Timothy S. Kowlton
Honigman, Miller, Schwartz & Cohn
222 N. Washington Square
Suite 400
Lansing, Michigan 48033

Mr. James Gerber
7700 Second Avenue
Detroit, Michigan 48202

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

Charles Raimi
Detroit Medical Center
3990 John R, 7 Brush West
Detroit, Michigan 48201

Joseph T. Aoun
Nuyen, Tomtishen & Aoun, P.C.
640 Griswold Street
Northville, Michigan 48167

Mr. Patrick J. Haddad
500 Woodward Avenue
Suite 2500
Detroit, Michigan 48226-3427

Mr. Gilbert M. Frimet
Mr. Alan Rogalski
32300 Northwestern
Suite 230
Farmington Hills, Michigan 48334

Mr. Michael R. Bell
525 West Ottawa Street
2nd Floor
P.O. Box 30754
Lansing, Michigan 48909

Ms. Wendy Hicks
7700 Second Avenue
3rd Floor
Detroit, Michigan 48202

Roger D. Young, Esq.
Steven Susser, Esq.
26200 American Drive
Suite 305
Southfield, Michigan 48034

Mr. E. John Blanchard
Mr. David W. Silver
P.O. Box 30754
Lansing, Michigan 48909

Mr. Ted K. Yasuda
233 North Michigan Avenue
7th Floor
Chicago, IL 60601

and depositing said envelopes in the U.S. mail, in Farmington Hills, Michigan.

Freda Ruginski

FREDA A. RUGINSKI

A

STATE OF MICHIGAN
CIRCUIT COURT FOR THE 30TH JUDICIAL CIRCUIT
INGHAM COUNTY

COMMISSIONER OF INSURANCE
FOR THE STATE OF MICHIGAN,

Petitioner,

v

MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC., a Michigan health maintenance organization, doing business as OmniCare Health Plan

Respondent.

File No. 98-88265-CR

Hon. James R. Giddings

A.G. No. 1998053333A

MARK J. ZAUSMER (P31721)
AMY M. SITNER (P46900)
Zausmer, Kaufman, August & Caldwell, P.C.
Attorneys for Petitioner
31700 Middlebelt Road, Suite 150
Farmington Hills, MI 48334
(248) 851-4111

AFFIDAVIT OF WINIFRED W. HICKS

STATE OF MICHIGAN)
) ss.
COUNTY OF WAYNE)

WINIFRED W. HICKS, being first duly sworn, deposes and states as follows:

1. The facts set forth below are known to me to be true and, if sworn as a witness, I can testify competently to the facts set forth below.

2. My employer, American Insurance Management, has been designated by

court order to be the Deputy Receiver for Michigan Health Maintenance Organizations Plans, Inc., formerly known as OmniCare Health Plan Inc. ("OmniCare").

3. As a representative of the Deputy Receiver I am familiar with the books and records of OmniCare and with its mode of operation before and during the pre-liquidation period during which it was undergoing court-supervised rehabilitation.

4. Before being placed into Liquidation, OmniCare was a health maintenance organization (HMO), providing services to members through a network of contracting providers.

5. When OmniCare members used network providers for medical services, the providers generally did not bill OmniCare members directly, except for co-pays, with payment for these services being made by OmniCare directly to providers.

6. If OmniCare failed to pay the providers, the providers were nevertheless generally barred from seeking payment for the services, except for the co-pay, from OmniCare members.

FURTHER AFFIANT SAYETH NOT.

WINIFRED W. HICKS

Subscribed and sworn to before me
this 7th day of July 2005

NOTARY PUBLIC
Wayne County, Michigan
My Commission expires: 8-17-07

(b) To the guaranty association for the costs and expenses of administration with respect to the payment of claims.

(c) To claims of Michigan policyholders of the insurer and to claimants of those Michigan policyholders.

(d) To Michigan beneficiaries of insurance contracts owned by non-Michigan residents.

(e) To other Michigan claimants of the insurer.

(f) To claims of non-Michigan policyholders of the insurer and to claimants of those non-Michigan policyholders.

(g) To non-Michigan beneficiaries of insurance contracts owned by non-Michigan residents.

(h) To the stockholders or owners of the insurer.

(2) Upon request of a guaranty association of this state to which the insurer is a member, special deposits made by the insurer shall be transferred to that guaranty association for the payment of claims pursuant to this section.

P.A.1956, No. 218, § 8141a, added by P.A.1989, No. 302, § 1, Imd. Eff. Jan. 3, 1990. Amended by P.A.1994, No. 443, § 1.

Historical and Statutory Notes

The 1994 amendment, in subsec. (1)(c), inserted "Michigan", and substituted "those Michigan" for "such"; inserted subsec. (1)(d); redesignated former subsec. (1)(d) as subsec. (1)(e); in subsec. (1)(e), inserted "Michigan"; inserted subsecs. (1)(f) and (1)(g); redesignated former subsec. (1)(e) as subsec. (1)(h); and, in subsec. (1)(h), substituted "owners" for "members".

P.A.1994, No. 443, § 2, provides:

"Section 8141a of Act No. 218 of the Public Acts of 1956, being section 500.8141a of the Michigan Compiled Laws, as amended by this amendatory act is curative, reflects the original intent of the legislature, is retroactive, and is effective beginning January 3, 1990."

P.A.1994, No. 443, was ordered to take immediate effect, and was approved January 7, 1995 and filed January 10, 1995.

Prior Laws:

P.A.1943, No. 158, § 7.
C.L.1948, §§ 500.7848, 550.207.
P.A.1956, No. 218, § 7848.
C.L.1970, § 500.7848.
C.L.1979, § 500.7848.

Cross References

Loans and investments, calculation of amount for contingencies, see § 500.901.

Library References

Insurance ⇐1414
Westlaw Topic No. 217
C.J.S. Insurance §§ 164, 166

500.8142. Priority of distribution of claims; classes

Sec. 8142. (1) Except as provided in subsection (2), the priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full or adequate funds retained for their payment before the members of the next class receive payment. Subclasses shall not be established within a class. The order of distribution of claims is as follows:

(a) Class 1. The costs and expenses of administration, including, but not limited to, the following:

(*i*) The actual and necessary costs of preserving or recovering the insurer's assets.

(*ii*) Compensation for all services rendered in the liquidation.

(*iii*) Any necessary filing fees.

(*iv*) The fees and mileage payable to witnesses.

(*v*) Reasonable attorney's fees.

(*vi*) The reasonable expenses of a guaranty association or foreign guaranty association in handling claims.

(*vii*) Debts due to employees for services performed to the extent that they do not exceed $1,000.00 and represent payment for services performed within 1 year before the filing of the petition for liquidation, if the court determines that the payments are reasonably necessary to an orderly and effective administration for the protection of class 2 claimants. Officers and directors are not entitled to the benefit of this priority. This priority is in lieu of any other similar priority authorized by law as to wages or compensation of employees.

(*viii*) Beginning January 3, 1990, the actual and necessary fees of a supervisor appointed pursuant to section 8109 [1] if the liquidation was preceded by supervision pursuant to section 8109 and the fees were not paid at the date of liquidation.

(b) Class 2. Except as otherwise provided in this section, all claims under policies for losses incurred, including third party claims, and all claims of a guaranty association or foreign guaranty association. However, obligations of an insolvent insurer arising out of reinsurance contracts shall not be included in this class. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, shall be treated as loss claims. For purposes of this section, life insurance and annuity policies include, but are not limited to, individual annuities, group annuities, guaranteed investment contracts, and funding agreement contracts, issued by an insurer. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities. A payment by an employer to his or her employee shall not be treated as a gratuity.

(c) Class 3. Claims of the federal government.

(d) Class 4. All claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property that are not under policies and, to the extent not included in class 1, debts due to employees for services performed to the extent that they do not exceed $1,000.00 and represent payment for services performed within 1 year before the filing of the petition for liquidation. Officers and directors are not entitled to the benefit of the priority for debts due to employees for services performed. The priority for debts due

to employees for services performed is in lieu of any other similar priority authorized by law as to wages or compensation of employees.

(e) Class 5. Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors.

(f) Class 6. Claims of any state or local government. Claims, including those of any governmental body for a penalty or forfeiture, are allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs incurred. The remainder of the claims shall be postponed to the class of claims under subdivision (i).

(g) Class 7. Claims filed late or any other claims other than claims under subdivisions (h) and (i).

(h) Class 8. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies are limited in accordance with law.

(i) Class 9. The claims of shareholders or other owners. In paying claims pursuant to this class, disinterested shareholders have priority over interested shareholders who are directors or officers who fail to exercise their duties in accordance with section 5240. [2]

(2) If it is provided by written agreement, statute, or rule that the assets in a separate account are not chargeable with liabilities arising out of any other business of the insurer, that part of a claim that includes a separate account shall be satisfied out of the assets in the separate account equal to the reserves maintained in the separate account under the separate account agreement. The remainder of the claim shall be treated as a Class 2 claim against the insurer's estate to the extent that reserves have been established in the insurer's general account pursuant to statute, rule, or the separate account agreement.

(3) As used in this section:

(a) "Separate account" means a separate account authorized under section 925 [3] and established in accordance with the terms of a written agreement or a contract on a variable basis.

(b) "Insurer's estate" means all of the assets of the insurer less any assets held in separate accounts. The following assets shall not be considered separate account assets:

(*i*) Assets that represent money provided by the insurer initially to fund the separate account.

(*ii*) Assets that represent policy reserves that are properly allocable to the general account.

(*iii*) General account investments held in the separate account.

P.A.1956, No. 218, § 8142, added by P.A.1989, No. 302, § 1, Imd. Eff. Jan. 3, 1990. Amended by P.A.1991, No. 79, § 1, Imd. Eff. July 18, 1991; P.A.1996, No. 429, § 1, Imd. Eff. Nov. 26, 1996; P.A.1998, No. 279, Imd. Eff. July 27, 1998; P.A.2002, No. 359, Imd. Eff. May 23, 2002.

[1] M.C.L.A. § 500.8109.